MMA Questions and Answers

ACRP

1. Q: Must ALL ACRPs for CY 2004 be resubmitted?

A: The Medicare Prescription Drug, Improvement and Modernization Act (DIMA) specifically says that if any part of an MA plan's service area includes a payment area for which the MA capitation rate is higher than the rate previously determined, the MA organization shall revise its submission. We anticipate that all service areas will receive a payment increase, and therefore, MA organizations must resubmit all current, CMS-approved CY 2004 ACRPs.

Please note that when we state that current, CMS-approved CY 2004 ACRPs must be resubmitted to CMS, this means that all ACRPs must be resubmitted, including employer only plan ACRPs.

2. Q: What is the deadline to submit revised/new ACRPs?

A: The deadline to submit either revised CY 2004 ACRPs for current plans or new ACRPs for MA organization s returning to the MA program or re-entering a previously reduced service area is midnight on January 30. Specifically, electronic versions of ACRs and PBPs must be uploaded to HPMS by midnight EST, January 30, and paper copies of ACRs must be postmarked by January 30.

3. Q: Will PPO Demonstrations be getting more instructions in addition to these instructions:

A: Yes. In addition to these instructions regarding submission of revised/new ACRPs, CMS will be sending additional information to the PPO Demonstrations shortly.

4. Q: If an MA organization renewed its MA contract in September 2004, when does a revised ACR (submitted in February 2004) become effective and what time period does it cover?

A: A revised ACR submitted in February will be an addendum to the approved ACR and will continue to cover the 12-month period beginning January 1, 2004 and ending December 31, 2004. The new payment rates and required changes in benefits, premiums, and cost sharing will be effective March 1. (See Question #24 of this section for more detailed information.)

5. Q: What modifications to ACRPs are permitted by DIMA?

A: MA organizations may make one or more of the following changes:

- reduce beneficiary premiums,
- reduce beneficiary cost sharing,

- enhance benefits,
- put additional payment amounts received under DIMA in a benefit stabilization fund, or
- use additional payment amounts to retain providers (stabilize access) or expand the provider network (enhance access), so long as this provider network stabilization or enhancement does not result in increased premiums, increased cost sharing, or reduced benefits.

6. **Q: DIMA allows an MA organization to reduce beneficiary cost sharing. Does this mean that an organization may convert coinsurance to a fixed dollar copayment if the amount paid by the beneficiary is reduced as a result?**

   A: Yes, this would be permissible as long as the cost sharing was reduced for all members.

7. **Q: If an MA organization reduces premiums or cost sharing or enhances benefits in a revised ACRP effective March 1, what premium and cost sharing should be charged and what benefits should be offered in January and February?**

   A: The premium, cost sharing, and benefits in a current CMS-approved ACR will be collected/offered in January and February. For example, if a plan effective January 1, 2004, contains a $50 premium whereas the revised plan effective March 1 contains a $25 premium, $50 must be collected from each enrollee in January and again in February. $25 must be collected each month from each enrollee March through December.

8. **Q: If an MA organization wishes to use a stabilization fund, where can more information on such a fund be obtained?**

   A: Qs&As on the stabilization fund are located below in the section labeled "Stabilization Fund".

9. **Q: Are MA organizations required to sign new contracts or amend current contracts as a result of the DIMA?**

   A: MA organizations returning to the MA program for CY 2004 must sign a new MA contract in advance of the effective date. The new contracts will reflect any new program requirements created by DIMA. MA organizations re-entering a previously reduced service area will be required to agree to amend their contracts at Attachment D to include the new counties they will serve. In both of these cases, CMS will send each applicable MA organization a new contract or modified contract agreement once notification is received of an MA organization's intent to return to the MA program or re-enter a previously reduced service area. In addition, the MA organizations identified here must return their 2004 contracts in advance of the effective date.

10. **Q: Are MA organizations permitted to update their currently approved ACRs with more recent and accurate data?**

A: Such changes are permissible as long as they do not result in a decrease in benefits or an increase in enrollee cost sharing. For example, updates to direct medical costs could include revised utilization, unit cost, risk scores, demographic, enrollment, and trend assumptions. Demographic and enrollment assumptions can be updated in the APR calculation and changes to the initial rate are also permitted. Increases to administrative costs are prohibited unless the increase has a significant direct relationship to stabilizing or enhancing beneficiary access to providers or directly related to enhanced benefits. Changes in assumptions concerning additional revenue are not permitted unless directly related to enhanced benefits. Changes to the base period costs on Worksheets A or B or the financial data on Worksheet B-1 are also not permitted. An organization may update data for some or all of its MA plans.

11. Q: What information should I include in the cover letter that accompanies the ACR?

A: A cover letter should accompany the hard copy submission of the ACR. For DIMA resubmissions of approved ACRPs for CY 2004, MA organizations must include the previously approved Average Payment Rate (APR), the new APR (using the higher rates calculated under DIMA only), and a summary list detailing how the increased payment will be used in each of the five DIMA categories (e.g., reduce cost sharing, enhance benefits). You must also display the share (expressed as a percentage or as a dollar amount) of the extra DIMA dollars used in each of the five DIMA categories. Following are examples of items to include in the detailed list on how the increase in payment will be used: reducing the premium from $50 to $25 ($25 PMPM), reducing the physician copay from $20 to $10 ($5 PMPM), adding a prescription drug benefit with a $500 annual maximum ($30 PMPM), etc. Resolutions of issues during the prior desk review process and any other pertinent information the MA organization wishes to make CMS aware of concerning the resubmission of the ACR under DIMA should also be included. For submissions of ACRPs covering new plans, refer to the cover letter instructions in the document *How to Transmit and Support your ACR for Contract Year 2004* on the CMS web site (www.cms.hhs.gov/healthplans/acr/).

12. **Q: If an MA organization chooses not to update approved ACRs with more recent data, will they still be in compliance with the certification statement that appears on Worksheet A of the ACR?**

A: Yes, if an exception statement is added to the cover letter. The certification statement that appears on Worksheet A of the ACR says: ". . . To the best of my knowledge and belief, this proposal contains true and correct statements prepared from the books and records of the contracting organization in accordance with applicable instructions, ***except as noted*** . . ." Exceptions to this certification should be noted in the cover letter. We suggest a statement similar to the following be included: *"<ABC Co.> is electing not to update projections or assumptions, but is only making the changes required by DIMA"*.

13. Q: Will new ACR worksheets be provided?

A: Yes. MA organization s must use the new version of the ACR (V2004.2). That version will be available on January 20, 2004 and will reflect the new payment rates for 2004.

14. Q: Can an MA organization delete any currently approved MA plans?

A: No, during the DIMA 2004 season, MA organizations cannot delete MA plans that have been approved by CMS. The current plan structure must be maintained.

15. Q: Can an MA organization consolidate two plans? For example, if an MA organization offers two plans in the same service are, can it now offer just one plan that includes all the members of both original plans?

A: No. As stated in Q&A #13, during the DIMA 2004 season, MA organizations cannot delete MA plans that have been approved by CMS. The current plan structure must be maintained

16. Q: Can an MA organization add new plans under DIMA?

A: Yes, new plans can be added as long as they meet the requirements for establishing new mid-year plans outlined in our June 6, 2003 instructions for the 2004 contract year (http://cms.hhs.gov/healthplans/letters/). However, due to time constraints, CMS will not approve new plans for a March 1, 2004 effective date. If you choose to add new plans, you cannot submit the new ACRP(s) for the plan(s) until March 1 (or later) – this is the case regardless of whether you plan to offer an exclusive Medicare endorsed prescription drug discount card with that new plan.

17. Q: Can an MA organization add plans using the currently approved service area under DIMA? For example, if an MA organization offers one plan covering two counties, can it now offer two plans, each covering one county?

A: No. We will not allow MA organizations to split up current plan structures/service areas. In this example, you must keep the existing plan with its existing service area, but you could also establish a new plan to also cover the one county (as per Question #16).

18. Q: Is it permissible to change or rearrange the service area-to-plan relationship under DIMA? For example, an MA organization offers 2 plans – plan 1 covering counties A & B and plan 2 covering county C. Can the MA organization rearrange the service area so that plan 1 will cover county A and plan 2 will cover counties B & C?

A: No, MA organizations cannot change the existing assignment of the service area to currently approved MA plans. Under DIMA, the current plan structure must be maintained.

19. Q: Can an organization add zip codes to a plan under DIMA?

A: No CMS will not allow MA organizations to expand the service area of a plan as part of a DIMA ACR filing. However, you can establish a new plan to cover the new zip

codes/service area by filing appropriate documents after the DIMA ACR season (see Question #16).

20. Q: Could an organization that withdrew from the MedicareAdvantage program in 2002 or 2003 re-enter the program as a result of the DIMA?

A: Yes. The law prevents any organization that withdraws from the MA program from re-entering the program for two years. However, CMS has the authority to waive this provision and we will waive it for the new DIMA ACRP season. An organization that left the MA program in January 2002 or January 2003 can request to re-enter the program. To do so, the organization must re-apply to become an MA organization. The instructions for applying to be an MA organization can be found at http://cms.hhs.gov/healthplans/applications/.

21. Q: Can an MA organization choose to offer a Part B Premium Reduction?

A: Yes, we would consider this a benefit enhancement and therefore it would be allowable under the DIMA. Instructions for how to submit an ACR with the Part B Premium Reduction can be found at http://cms.hhs.gov/healthplans/acr/appdx1.pdf, Chapter 2, Part III. Please keep in mind that even though the reduction would go into effect on March 1, your members would not actually begin to see the increase in their Social Security checks until about June 2004 (this check will include the retroactive adjustment back to March 1).

22. Q: What are the consequences of any MA organization being unwilling or unable to file a revised ACRP by the deadline of January 30?

A: If an MA organization renewed its contract in September 2003 for CY 2004 and fails to timely submit a revised ACRP, CMS will automatically place the additional payment in a stabilization fund for the plan effective March 1. In addition, sanctions can be imposed for non-compliance. We will continue to accept new MA applications and service area expansion applications after January 30.

23. Q: If an MA organization's CY 2003 ACR was audited, can those items identified as audit findings be corrected in a revised submission of a CY 2004 ACR?

A: Yes, those items identified as findings in the audit of the CY 2003 ACR may be corrected in a revised submission of a CY 2004 ACR. However, such corrections are not required.

24. Q: Since the ACR covers the 12-month period beginning January 1, 2004 and ending December 31, 2004, but the change in benefits and cost sharing is not effective until March 1, how should I enter the data in the ACR & PBP?

A: All values entered in the ACR & PBP should reflect the premium, cost sharing, and benefits that will be effective beginning March 1. The Average Payment Rate (APR) on Worksheet A1 should be calculated using only the new, higher rates provided for under DIMA. In addition, you will have to adjust the APR under the new rates to reflect catch-up payments for January and February since CMS will be paying MA organizations

retroactively for the January and February time periods. CMS will make instructions covering the catch-up payments available in mid-January. Changes to Worksheets A, C, and D should be made pursuant to DIMA (see Question #5 of this section). The premium entered in the ACR should match the premium in the PBP. No weighting of any values is necessary.

25. Q: If I did not renew my contract or reduced my service area in September 2003 for CY 2004 and I wish to return to the MA program or re-enter the previously reduced service area, must I return to the entire service area covered in CY 2003?

A: No, MA organizations returning to the program or re-entering a previously reduced service area can return to all or part of the CY 2003 service area.

26. Q: Why is it important that I notify CMS in a timely manner if I plan to return to the MA program or re-enter a previously reduced service area?

A: Upon receipt of written notification from an MA organization that wishes to return to the MA program or to re-enter a previously reduced service area, CMS will take the appropriate changes in the HPMS to permit MA organizations to create one or more new plans covering the newly available county or set of counties and to download the new ACR(s) and PBP(s). If CMS does not receive the written notification in a timely manner, the process of creating plans and downloading the ACR(s) and PBP(s) will be prohibited until CMS receives such notice. This reduces the amount of time an MA organization has to complete its ACR(s) and PBP(s).

27. Q: Whom do I contact if my HPMS password needs to be reset?

A: Please contact Don Freeburger at either 410-786-4586 or DFreeburger@cms.hhs.gov.

28. Q: Whom do I contact for technical assistance on the HPMS while preparing and submitting my ACRPs?

A: Please contact the HPMS Help Desk at either 1-800-220-2028 or hpms@nerdvana.fu.com. You may also contact Kristin Finch at (410) 786-2873 or kfinch@cms.hhs.gov with HPMS questions.

29. Q: Whom do I contact for technical assistance on the ACR worksheets?

A: Please contact LMI at either 703-917-7236 or jo'keiff@lmi.org.

30. Q: Where can I find the new payment rates provided for under DIMA?

A: You can find them at www.cms.gov/stats/hmorates/aapccpg.htm

31. Q: Are certification signatures required on each and every ACR submitted?

A: Yes, the CFO and CEO must sign each and every ACR submitted under DIMA. For ACRs that must be resubmitted after the initial DIMA resubmission, refer to page 27 of the *Instructions for Completing the Adjusted Community Rate Pricing Form for Contract Year 2004* on the CMS web site (www.cms.hhs.gov/healthplans/acr/) to determine when the certification on Worksheet A must be completed.

If your organization cannot provide the original copy of a signed Worksheet A at the time of your ACRP submission, you can submit your ACR without the signatures. In that case, make a notation in the cover letter letting CMS know you plan to send a signed Worksheet A for your initial resubmission under separate cover. You have until February 13, 2004, to submit the signed Worksheet A. CMS will not approve your ACR if you fail to submit the original, signed Worksheet A by February 13, 2004.

32. Q: What documentation must accompany the ACR, especially with regards to documenting the use of additional payment to stabilize or enhance the provider network?

A: MA organizations that are returning to the MA program or are re-entering a previously reduced service area must submit a new ACRP with a full set of written, supporting documentation. See the DIMA ACRP instructions for a complete list of requirements. Organizations re-submitting CMS-approved plans must submit substantiation only for those items that changed from the approved version. If all or part of the additional payment is used to stabilize or enhance the provider network, a narrative is acceptable. The narrative should state clearly how those funds "stabilize" or "enhance" the provider network and the PMPM amount attributable to this use should appear on the cover letter (see Question 11). MA organizations should be aware that CMS auditors will verify the narrative during audit. Therefore, please be prepared to provide materials supporting the narrative.

33. Q: How do I reflect the new Medicare-covered benefits in the ACR and PBP?

A: Include the additional cost for the new Medicare benefits in the ACR as an expected variation on Worksheet D. Also, you can add additional language to the note fields in the PBP.

34. Q: Must I resubmit ACRPs for Part B-only plans? What if I no longer have any Part B-only members?

A: All ACRPs must be resubmitted, including those for Part B-only plans. However, if an MA plan no longer has Part B-only members, a resubmission of the Part B-only ACRP(s) is not required. Instead, the MA organization must notify CMS by January 23, in writing, of which of its MA plans no longer has Part B-only members.

35. Q: Since the statute does not distinguish between types of premiums that may be reduced, is a reduction in premium for an optional supplemental benefit or mandatory supplemental benefit permissible?

A: No, MA organizations cannot use increases in the payment rate to reduce premiums (or cost sharing) for supplemental benefits. The payment received from CMS covers Medicare-covered and additional benefits, but not mandatory supplemental or optional supplemental benefits. However, an MA organization can move a benefit from either the optional supplemental or the mandatory supplemental benefit category to the additional benefit category. In addition, an MA organization can reduce premiums (or cost sharing) for supplemental benefits if it does not use government payments to cover the reductions.

36. Q: We have discovered that the initial rate in our approved ACR is understated and wish to update it in our submission under DIMA; however doing so would increase the non-Medicare additional revenue and the instructions state that additional revenue can not increase from the current approved PMPM value. In this case, can the Medicare additional revenue increase accordingly?

A: The initial rate for the contract period on Worksheet A, Part IB, column b can be adjusted to reflect a more accurate estimate that may result in an increase in additional revenue for non-medicare enrollees; However, in this particular situation, the additional revenue PMPM amount on Worksheet D for Medicare enrollees must not exceed the PMPM amount that CMS previously approved for CY 2004. In other words, a negative adjustment must be made on Worksheet D to ensure that the new value does not exceed the approved additional revenue value (i.e., cannot be a bigger positive amount or a smaller negative amount than CMS has approved). Of course, as explained in the answer to Question 10, additional revenue PMPM amounts can be increased if the increase is directly related to enhanced benefits.

37. Q: Can an MA organization increase some cost sharing and decrease other cost sharing as long as the total PMPM value is the same? For example, if a plan has an approved $10 generic drug copay and a $20 brand name drug copay, could the copays be changed to $5 generic and $25 brand if it could be shown that this design has the same PMPM value as the approved ACR?

A: No, cost sharing cannot increase for a currently approved benefit. Though the PMPM value does not change on an average basis, cost sharing would be increased on an individual basis.

38. Q: Can an MA organization use the increase in payment to reduce or eliminate projected losses?

A: No, the increase in payment cannot be used to reduce or eliminate projected losses. In other words, the approved additional revenue PMPM value cannot be increased in the ACR submitted under DIMA unless the increase is directly related to enhanced benefits.

39. Q: Assume an MA plan wishes to offer an exclusive Medicare discount card to its members. Can the MA plan use part of the DIMA payment rate increase to cover its administrative costs?

A: Yes. The plan can use part of the DIMA payment increase to pay for the administrative cost of the card. However, the plan cannot use more than $30 per member *per year* ($2.50 per member *per month*) to pay for such costs. Furthermore, using the DIMA payment increase to pay for such administrative costs will affect the maximum allowable amount that a plan can charge enrollees electing the card. If the plan wishes to charge an enrollment fee for the card it can charge up to $30 per card enrollee per year *less* the amount of the annual administrative costs covered by the DIMA payment rate increases.

40. Q: Can an MA organization returning to the MA program or re-entering a previously reduced service area have a CY 2004 service area that is larger than its CY 2003 service area?

A: Yes. However, the MA organization must apply for a service area expansion that CMS would then review in accordance with its standard application review procedures for such expansions.

Stabilization Fund

Effective January 1, 2006, all monies in stabilization funds will be forfeited to the Medicare Trust Funds. All MA organizations must keep this fact in mind when deciding whether or not to add the DIMA 2004 monies to a stabilization fund.

During the 2004 DIMA ACR season, CMS has the authority to allow MA organizations to take any monies out of their stabilization funds to use them as part of the DIMA resubmission during the DIMA season. Therefore, if an MA organization has a balance remaining in its stabilization fund, we advise it to consider this option to prevent any monies from being forfeited to the Medicare Trust Funds. If an organization chooses to use stabilization monies for part of the DIMA resubmission, keep in mind that those monies must only be used to provide additional benefits to members.

1. Q: What is the stabilization fund?

A: The stabilization fund is a monetary reserve held by the federal government on behalf of MA organizations for the Medicare enrollees of a specific MA plan. The fund is financed from amounts that individual MA organizations ask CMS to withhold from government payments due on MA contracts. The fund will be in place through December 31, 2005.

2. Q: For what can money placed in the stabilization fund be used?

A: The money can be withdrawn by the contributing MA organization to stabilize and prevent undue fluctuations in "additional benefits" of the MA plan that originally contributed to the fund.

3. Q: Is advance notice required for deposits to and/or withdrawals from the stabilization fund?

A: Yes. Requests for CMS approval of contributions and withdrawals generally must be made in the annual ACRP submissions. Contributions may also be made in a revised ACRP submitted pursuant to the DIMA, as discussed in Question 22 below.

4. **Q: Will the government hold amounts deposited in the stabilization fund indefinitely on behalf of MA organizations?**

   A: No. The government will hold fund amounts reserved for a specific MA organization until the MA organization withdraws all of the reserved funds, terminates the MA plan that established the fund, or until the expiration of the holding period specified by the MA organization, or until December 31, 2005, whichever comes first.

5. **Q: Do government regulations limit the amount that my MA organization may have withheld for any MA plan?**

   A: Yes. Generally CMS will not approve requests for withholding under a specific adjusted community rate (ACR) for a specific contract period if the requested amount would 1) exceed 15 percent of an MA plan's excess amount for the contract period and/or 2) cause the total cumulative amount in the stabilization fund for a specific MA plan to exceed 25 percent of the excess amount for that plan for that contract period. However, federal regulations provide for an exception to the 15 percent limit. See Question 22 below for discussion of an additional exception to the above limits provided for in DIMA.

6. **Q: Do federal regulations authorize an exception to the 25 percent cumulative limit on withholding for a plan's stabilization fund?**

   A: No. However, see Question 22 below for an additional explanation of this general rule.

7. **Q: Can my MA organization withdraw money from its stabilization fund whenever it wants?**

   A: No: Advanced notice is required, and the conditions listed in 42 CFR 422.312(c)(5) must be met. Briefly, these conditions are:
   - The average payment rate (APR) of an MA plan is decreasing;
   - The MA plan's ACR is significantly increasing;
   - The value of additional benefits reported in the current ACR submission is significantly increasing over the value of additional benefits reported in the previous ACR submission; or,
   - The modified ACR (ACR for Medicare covered benefits less the actuarial value of Medicare's Deductibles and coinsurance) is increasing at a faster rate than the MA plan's APR.

   The MA organization must notify CMS of its intent to withdraw money from its stabilization fund in the ACR for the plan associated with the stabilization fund. CMS will not allow a withdrawal from the stabilization fund if the money is used to refinance prior contract period losses or only to avoid losses in the upcoming contract period.

8. **Q: How does the government record reserved funds?**

   A: Reserved funds are held in a stabilization fund uniquely identified to *each* participating MA organization and within that, reserved funds are uniquely identified to *each* participating MA plan. Within each stabilization fund, annual contributions and withdrawals are recorded separately by MA plan to account for the holding period specified in the relevant ACR.

9. **Q: Must an MA organization use its reserved funds exclusively for stabilizing additional benefits for the MA plan under which the funds were withheld?**

   A: Yes. To the maximum extent possible, reserved funds must be used to benefit the Medicare enrollees of the MA plan under which the funds were originally withheld.

10. **Q: If my MA organization requests withholding for a stabilization fund from the same MA plan in different contract years, must it specify the same holding period?**

    A: No.

11. **Q: Under normal circumstances not pursuant to DIMA, I understand that federal regulations permit an exception to the 15 percent limit on annual withholding to finance a plan's stabilization fund. How will CMS implement the exception?**

    A: CMS will require MA organizations applying for the exception to demonstrate, using *actual* data, that the additional benefits provided to Medicare enrollees electing the plan varies by more than the 15 percent limit from year to year. See Question 22 below for discussion of an additional exception to the above limits provided for in DIMA.

12. **Q: Is the authorized exception to the 15 percent limit on annual withholding for a plan's stabilization fund available to new MA plans?**

    A: No. See Question 22 below for discussion of an additional exception to the above limits provided for in DIMA.

13. **Q: My MA organization wants to withdraw funds withheld for an MA plan we no longer offer. How should we document that request?**

    A: If your organization terminated the MA plan, the amount in the stabilization fund reserved for that plan would have been forfeited to the Medicare trust funds.

14. **Q: My MA organization wants to withdraw funds withheld for an MA plan, but we plan to drop out of the MA program next year. How do we get the funds back?**

    A: If your MA plan meets one of the conditions outlined in question 7, the organization may withdraw money from the stabilization fund. However, if your organization terminated the

MA plan, the amount in the stabilization fund reserved for that plan would be forfeited to the Medicare trust funds.

15. Q: After my company's ACR for an MA plan has been approved, can we change the level of contributions we proposed to make to the stabilization fund?

A: No.

16. Q: After my company's ACR for an MA plan has been approved, can we change the amount proposed for withdrawal from a stabilization fund?

A: No.

17. Q: If my company has a stabilization fund, can it choose to avoid contributing to or withdrawing from it during a specific contract period.

A: Yes. Regulations generally don't force you to take any specific actions related to your reserved funds. However, if your fund-holding period(s) would expire during that contract period, you should consider, if you meet the conditions outlined in question 7, withdrawing the reserved funds. Otherwise, they will be forfeited to the Medicare trust funds when the holding period expires.

18. Q: My organization wants to withdraw reserved funds during the next contract period, but we don't expect to offer any additional benefits in our MA plan. Can we withdraw reserved funds?

A: It depends. The MA plan must meet at least one of the conditions outlined in question 7 in order to withdraw from the stabilization fund.

19. Q: When can MA organizations withdraw amounts from the stabilization fund?

A: The reserved funds can be withdrawn by a contributing MA organization in contract periods after the ones during which the reserves have been deposited.

20. Q: Can an MA organization both contribute and withdraw reserved funds during a contract period?

A: Yes, but only if the MA organization has more than one MA plan and the contributions and withdrawals relate to different MA plans offered by the MA organization. In other words, MA organizations can have more than one MA plan and thus, can have more than one stabilization fund. Each stabilization fund is related to a specific MA plan. Therefore, assuming an MA organization with multiple MA plans in a specific contract year, one of its plans can contribute to the plan's stabilization fund while another of its plans can withdrawals from the latter plan's stabilization fund.

21. Q: My organization offers more than one MA plan. We will reserve funds in a stabilization fund for one of our plans during contract year 2004. Do we have to reserve funds in our other plans?

A: No.

22. Q: In accordance with the passage of the DIMA, CMS's payments for the MA plan offered will increase. My company would like to contribute the entire increase in MA plan payments to the stabilization fund. This contribution should increase the MA plan stabilization fund balance greater than the limit (25% of excess amount). Will CMS allow this contribution? Next year, will the MA plan be able to contribute any more money to the stabilization fund?

A: The DIMA requires MA organizations to submit or revise its ACRs for calendar year 2004. Section 211 waives all limits associated with the stabilization fund for these ACRs. Therefore, an MA organization may contribute all or part of the increase in payments for a particular MA plan into a stabilization fund. In subsequent years, MA organizations will not be allowed to make additional contributions to an MA plan's stabilization fund until the balance remaining in that fund is less than the 25% of the excess amount limit for that plan.

Marketing Material Review

1. Q: Given the DIMA timeframes and the March 1 effective date for the new MA payment rates, how quickly will CMS review marketing materials?

A: CMS's review of MA organizations' marketing materials will be conducted concurrently with the ACRP submission review process. We will follow the streamlined marketing review process, which means that final approval of marketing materials will be granted before until the ACRP has been approved and the MA organization must use the "pending Federal approval" disclaimer. Details about the review process are included in the ACRP instructions.

2. Q: We may get calls from members about Medicare Reform. What can we tell them now?

A: You can tell your members general information about the new bill (for example, it allows you to enhance your benefits, it allows you to develop a Medicare-endorsed prescription drug discount card, etc.). You may also let them know if you plan to offer a Medicare-endorsed prescription drug discount card or to enhance benefits. However, at this time you may not describe those new benefits or give more details about the card. You must wait until you have approved marketing materials before you may give this level of detail.